The Boulevard
The Road to Health and Home
formerly Interfaith House

FACSIMILE TRANSMITTAL SHEET

TO:	FROM: Anais Fuentes
COMPANY:	DATE:
FAX NUMBER:	TOTAL NO. OF PAGES INCLUDING COVER:
PHONE NUMBER:	SENDER'S PHONE NUMBER: 773-533-6013 x231
RE:	SENDER'S FAX NUMBER: 773-533-3930

☐ URGENT ☐ FOR REVIEW ☐ PLEASE COMMENT ☐ PLEASE REPLY ☐ PLEASE RECYCLE

NOTES/COMMENTS:

The Boulevard is a congregate facility and will take every precaution to keep our residents safe. Thus, we continue to adhere to the guidelines set forth by the CDC/CDPH and have made some changes in our referral process and intake procedure;

Please see the attached checklist for additional information. We look forward to serving your patients soon.

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REFERRAL CHECKLIST

The Boulevard is a residential facility accepting homeless adults who need time and a safe, clean place of respite to complete their recovery from a medical condition under the care of their referring institution. The Boulevard is not a medical, psychiatric, or substance abuse treatment center, but serves as a place where individuals can safely recuperate and access needed services. Please use this checklist to help guide you through our referral process. We cannot accept a referral until all of these items have been completed.

Thank you.

Anais Fuentes
Intake Hours: 8:00 AM – 4:00 PM Monday through Thursday; 8:00 AM – 3:00 PM on Friday
Intake Phone Number: (773) 533-6013, extension 231. Intake Fax Number: (773) 533-3930
Or (773) 533-9034

____ Fax in the completed Referral Application Form (at this point the client will be added to the wait list, pending completion of the referral process and approval of the client)

____ Fax in the completed Tuberculosis Test Verification Form

____ Fax in the completed Signed Medical Diagnosis Form, this form should be completed by a Physician, stating whether or not the individual has HIV/AIDS

____ Fax in the completed Homelessness Verification Form

____ Discuss The Boulevard's program and our conditions of residency with the client, which briefly include: following their medical recovery plan, participating as medically capable in house activities and programs, and respecting fellow clients, staff, the facility, rules and procedures. Residents will be living in a diverse, community setting and are expected to be able to share general living spaces, including bedrooms and bathrooms.

____ Arrange for a time in which our Intake Administrator can speak with the client by phone.

____ Arrange for the client to arrive at The Boulevard with a 30-day supply of all needed medications and medical supplies (unfilled prescriptions **do not** meet this requirement).

____ Arrange for Home Health Care if the client will need assistance with any basic living skills (please refer to basic living skills that are listed on the Referral Application Form).

____ Arrange for needed follow-up medical and psychiatric appointments.

____ Arrange for transportation to The Boulevard upon acceptance of referral.

The items listed below are helpful to us when working with new clients. If applicable, please fax us copies of the following: Psychiatric assessments, recent toxicology results (needed to see if this is an issue interfering with medical care and recovery) medical insurance cards, proof of income (The Boulevard does not charge for services), any other medical records as requested by our Intake Administrator.
Once our Intake Administrator confirms that all of the above items have been completed and the client is appropriate for our program, you will be notified when a bed becomes available.

WHO SHOULD COME TO THE BOULEVARD?

- Single men and women who are homeless and being discharged from the hospital needing a short term placement (four to six weeks) in order to complete their recovery from a physical illness or injury, are mentally stable and those that request assistance with substance abuse issues. **The Boulevard is not appropriate for patients requiring long term nursing home care.**

- Patients who can physically care for themselves (e.g. dress, bathe, self-ambulate, attend to their personal hygiene and take medication as prescribed), who no longer require bedside nursing care, can come to the dining room for meals, make their bed, and keep their living space neat. The Boulevard provides support to residents to complete their healing *but it is not a medical treatment facility*.

- Patients who understand their care plan and can carry out the measures necessary to implement them with the help of The Boulevard staff, including compliance with medications and returning to their primary care physician for follow-up care.

- Patients who are able to live in a communal environment, share a bedroom with four or five roommates, share meals in a common dining room with 64 residents, participate in educational sessions and group meetings and follow The Boulevard conditions of residency.

**In order to provide the best possible service to residents, it is vital that all medical conditions and mental health history be shared with the Intake Administrator.*

SERVICES PROVIDED

ONE-TO-ONE CASE MANAGEMENT – Upon admission, each resident is assigned a case manager who offers guidance in obtaining financial assistance, housing opportunities, employment or employment training, and educational opportunities.

HEALTH SERVICES – Nearly 70 percent of our residents have no relationship to a primary care physician or ongoing health services when they arrive. To respond to this need we worked with PCC Community Wellness Center to open our Health Services Collaborative, offering a variety of vitally important health services in an on-site clinic staffed by physicians and nurse practitioners from partnering institutions. In addition, we offer transportation for follow-up medical visits if the resident is unable to self-transport and, residents are provided a safe place to store their medications.

BEHAVIORAL HEALTH – On-site Mental Health Case Managers assess incoming residents and make appropriate referrals to mental health services. The Boulevard offers substance abuse assessment, one-to-one support and additional programming to serve our clients who struggle with substance abuse.

HIV/AIDS – The Boulevard partners with local HIV/AIDS outreach services to provide confidential on-site testing and counseling; access to primary care, psychosocial support programs, and medications; supportive housing referrals; and weekly HIV/AIDS/STD education programs.

Making a Referral to The Boulevard

Please complete our Respite Intake Form and **fax** it to the Intake Administrator at **773.533.3930**. Follow-up calls to our Intake Administrator should be made at **773-533-6013 ext. 231**. Intake hours are **Monday through Thursday** between the hours of **8:00 a.m. and 4:00 p.m. and between the hours of 8:00 a.m. and 3:00 p.m. on Friday**. Referrals after business hours must be made through the **Chicago Department of Family and Support Services.**

The Boulevard is an ADA accessible residential facility accepting homeless adults who need time and a safe, clean place to complete their recovery from an acute medical condition, although referrals that have an acute medical condition with a secondary mental illness or substance abuse history may be accepted.

RESIDENTS REFERRED TO THE BOULEVARD MUST BE:

- Mentally alert and psychiatrically stable with medication if needed.
- Able to participate in their own medical care plan
- Able to manage basic living skills without assistance
- Living with an acute medical illness or injury
- Expected to recover in 30 days or less
- Provided a 30 day supply of medications/medical supplies

REFERRING MEDICAL FACILITIES MUST:

- Transport each referral with 30 day supply of medication to The Boulevard by 3:00 p.m.
- Identify a primary care physician who will prepare and be responsible for the referral's comprehensive medical recovery plan.
- Obtain informed consent from the referral for all aspects of such medical care plan prior to transfer to The Boulevard.

Referral Name:________________________________ DOB:_______________

Referral Source:___________________________ Date:_______________

Please fill out the following prior to the acceptance and transfer of the client

****** **Has the patient tested positive for COVID-19?**
Yes ________No________

Did the patient have symptoms of COVID-19: Yes________ No___________?

Date of symptoms onset: _ _______________________

Symptoms:
____

Hospitalized: Yes_____ No______ Length of hospitalization:______________

If yes, name of the hospital: ____

Name of facility after hospitalization: ____________________________________

Length of stay at facility: ____

For the patients who had **symptoms (this includes patients who initially may have been asymptomatic when they first tested and then developed symptoms later)**

4. Have passed at least 3 days (72 hours) without a fever (100.0 or above) without the use of medications to reduce the fever:
Yes___________ No_________________

5. Have the symptoms in the past 3 days (72 hours) resolved or improved:
Yes___________ No_________________

 Please fax to (773) 533-3930

REFERRAL APPLICATION

Client name: ________________________________ Date of birth: ____/____/______

SSN: _________________________________ Gender: ___Male ___ Female ___Transgender

Phone Number:_____________________________ (will be used for phone screening)

Preferred language: ___English ___Spanish ___Polish ___Other:_____________________

Race ethnicity: ___African-American ___Hispanic-White ___Hispanic-Black ___Caucasian
___Native-American ___Asian/Pacific Islander ___Other:_________________

Referring institution/physician: ____
Name Phone/Pager # Fax#

Referring social worker: ____
Name Phone/Pager# Fax#

Client's last permanent address: ____

Zip code: _________________

Emergency contact person: ______________________________ Relationship:________________

Address:________________________________ Phone: ___________________________

Please check the situation that most accurately defines the client's living situation prior to hospitalization. All referrals must be homeless as defined by HUD:

___ Living on the street
___ Emergency Shelter
___ Transitional Housing
___ Evicted: formal proceeding
___ Evicted: by family/friend
___ Evicted: informal
___ Institution: less than 31 days
___ Institution: greater than 31 days
___ Domestic Violence

Is client a citizen of the United States?_____________
Is this the client's first time being homeless? ________ Number of times homeless? ________

Does the client have an income? ____________ Source of Income: _________________________

Contact information for prior living situation:____
If different from permanent address and/or emergency contact

Address:________________________________ Phone: ___________________________

Date of hospital admission: ____/____/______ through ___________________________________
Estimated date of discharge

Please describe the client's current mental status (e.g. confused, alert, disoriented, tearful, etc.):

____

Does the patient have a psychiatric history? ___No ___Yes: Date of diagnosis_______________

If yes, what is the diagnosis? Axis I ___________________ Axis II___________________

If no, does the client currently present any of the following:

Cognitive impairment (e.g. memory, judgment) ___Yes ___No
Thought disorder ___Yes ___No
Dementia ___Yes ___No
Paranoia ___Yes ___No
Confusion ___Yes ___No

Acute/Principle illness or injury:____

Disabilities (check all that apply):
Hypertension ____
HIV/AIDS ____
Seizure disorder ____
Diabetes ____
Alcohol abuse ____ Last used:___________
Drug abuse ____ Last used:___________
Substance(s) used:____________________
____

Medications & supplies that will be needed by client at time of discharge & reason for need *(please note that we are a drug-free environment. If pain medications are needed, if possible, please consider non-narcotic based options).*

1. ____________________________________ 6. ____________________________________
2. ____________________________________ 7. ____________________________________
3. ____________________________________ 8. ____________________________________
4. ____________________________________ 9. ____________________________________
5. ____________________________________ 10. ____________________________________

Is the client taking Methadone? Yes No If yes, what dose and for what reason?

____

Upcoming medical/psychiatric follow-up appointments (Location/Date/Time/Phone Number):

1. ____
2. ____
3. ____

Type of insurance: (***Please check all that apply***)
___None ___Medicaid ____Aetna ___Humana ___ IlliniCare ___ CountyCare ____Meridian
____Molina Health _____ Medicare A/B ___Veterans Administration ___HMO/Private
___ Other_________________

Is client able to manage the following basic living skills **without assistance**:

Showering/hygiene	___ Yes ___ No	Take medication as prescribed	___ Yes ___ No
Dressing his/herself	___ Yes ___ No	Change medical dressings	___ Yes ___ No
Manage bowel/bladder	___ Yes ___ No	Manage all other medical supplies	___ Yes ___ No

If no to any of the above, how will the client need assistance?_____________________________

____

Has The Boulevard's program been discussed with the client, is he/she interested and willing to be referred to our program, and has informed consent been obtained? ___Yes ___No

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THE BOULEVARD REFERRAL
TUBERCULOSIS TEST VERIFICATION

Due to serving a high-risk population and the fact that our clients will be living in a community setting, it is vital that we have current (**within the past 30 days**) verification of negative tuberculosis status *even if the client is not currently displaying any signs or symptoms of active TB*. Please refer to the following guidelines of what constitutes adequate testing and documentation for admission to our program.

1. PPD placement: A negative PPD test is adequate if it was placed within the past 30 days and was read within 72 hours of placement.
2. Chest X-ray: For clients with positive PPD test results or a history of positive PPD test results, a recent (within the past 30 days) chest x-ray with normal results or showing no signs of tuberculosis is adequate.
3. Three negative sputums: For clients who were treated for active tuberculosis, we require three negative sputum results collected and tested on different days.

Please document the TB testing that was done for the client and **fax in copies of any PPD results, chest x-ray reports, and/or sputum results**.

Client Name: ______________________________ SSN:______________________________

Location of TB testing: ____
Medical Facility/Organization

PPD placed: ____/____/____ PPD read:____/____/____ Result: ___ Negative ___ Positive
____ mm in duration

Chest x-ray: ____/____/____ Result: ___ Normal/No sign of active TB ___ Abnormal

Sputum results:
Sample One:____/____/______ Result: ___Negative ___Positive
Sample Two:____/____/______ Result: ___Negative ___Positive
Sample Three:____/____/______ Result: ___Negative ___Positive

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SIGNED MEDICAL DIAGNOSIS

Client name: ____________________________

SSN: ____________________________ Date of birth: _____/_____/_______

Referring institution:____

ICD/10 Code: ______________________ Primary acute Diagnosis:____________________

ICD/ 10 Code:______________________ Secondary Diagnosis:______________________

ICD/10 Code 3: ______________________ Diagnosis:_____________________________

ICD/10 Code 4: ______________________ Diagnosis:_____________________________

ICD/10 Code 5:______________________ Diagnosis:_____________________________

Client has a disability: _____ Yes _____ No Disability type: _____Physical _____ Mental

Based on the patient's medical diagnoses, s/he: _____ ***SHOULD*** apply for disability benefits.
_____ ***SHOULD NOT*** apply for disability benefits._____ Patient already has disability benefits.

If the client is impacted by HIV/AIDS, please complete the following:

Date of HIV diagnosis:____/____/_____

Date of AIDS diagnosis (if applicable):____/____/_____

Location of HIV/AIDS treatment:____

CD4 count:______________________ Date of test: ____/____/______

Viral load:_______________________ Date of test: ____/____/______

TB test results:___________________ Date of test: ____/____/______

Current status (please check):
____ HIV-Asymptomatic ____ HIV-Symptomatic ____AIDS

Physician's Printed Name: ________________________________

Physician's Signature:___________________________________ Date:____/____/______

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HOMELESSNESS VERIFICATION

TO BE COMPLETED BY APPLICANT

Please check the statement which applies to your current housing situation and complete the *Applicant Certification* below. Service provider's who can verify your homelessness situation must complete the bottom portion of this form.

- ☐ I am without housing and live on the streets, in a car, non-residential building, etc.
- ☐ I am without housing and spend nights in a shelter, institution, or temporary housing.
- ☐ I am staying with another family (for < 30 days) and there are not enough beds for everyone.
- ☐ I am at risk of losing housing due to eviction, sale of housing, loss of income, or other crisis. (Documentation of Eviction is required – 14 days or less)
- ☐ I am fleeing a domestic violence situation.

APPLICANT CERTIFICATION

I hereby certify that the information I am providing is true and accurate. I lack the resources and support networks needed to obtain housing.

______________________	______________________	______________
Printed Name of Head of Household	Signature of Head of Household	Date

TO BE COMPLETED BY SERVICE PROVIDER

HOMELESSNESS STATUS VERIFICATION

I CERTIFY THAT________________________________ (applicant) IS HOMELESS.

- ☐ The applicant is staying in a place not meant for human habitation (parks, sidewalk, etc.)
- ☐ The applicant is staying in a shelter (Emergency, Transitional, Supportive)
  Name of Shelter: ____
- ☐ The applicant is staying a short time (30 days or less) in a hospital or institution.
- ☐ The applicant lives with another family which does not have sufficient beds for everyone
- ☐ The applicant is being discharged from an institution, (Mental Health, Substance abuse or Jail/Prison) where he/she has resided for more than 30 consecutive days.
- ☐ The applicant is fleeing a domestic violence situation.

______________________	______________________	______________
Printed Name of Service Provider	Signature of Service Provider	Professional Title
______________________	______________________	______________
Organization	Phone Number	Date

Please fax to (773) 533-3930